

EXHIBIT 1
Department of Alcohol and Drug Programs
HIPAA Survey

Please answer the following questions regarding the HIPAA involvement of your program or services.

- 1) **Name of County or Direct Provider:** _____
- 2) **Has a HIPAA Coordinator or Contact Person been assigned to this program or service? Yes ____ No ____**
 - Name of Contact Person for HIPAA: _____
 - Mailing Address: _____
 - City, State and Zip: _____
 - Phone number: _____
 - E-Mail: _____
 - Employer Identification Number: _____
(Current Tax ID#)
- 3) **Which of these statements best describes your Alcohol and Other Drug Programs (AOD) HIPAA status (Check all that apply):**
 - ____ We are just beginning to learn about HIPAA.
 - ____ We are in the process of developing a HIPAA compliance project plan.
 - ____ We have compiled an inventory of our local HIPAA needs.
 - ____ We have assessed the impact HIPAA compliance will have on our programs.
 - ____ We have an understanding of the scope of work necessary to become HIPAA compliant and we have a defined strategy.
 - ____ Other (Please specify): _____
- 4) **If your program or service is impacted by HIPAA, please list each program or service that is impacted. List all that apply.**
- 5) **Describe the main issues your program or service is facing with regards to AOD HIPAA?**
- 6) **Does your area store health information about individuals electronically on computer, diskette, CD, or magnetic tape?**
- 7) **Does your area send or receive health information from business partners or any outside entity? If so, how is this information transmitted? Please be specific.**
- 8) **Please write the name, telephone number and email address of the person completing this survey:**

_____	_____	_____
Name	Telephone number	Email Address

Please return this survey by Friday, November 16, 2001 to:
Donna Haddad
Department of Alcohol and Drug Programs
1700 K Street, 4th Floor, Sacramento, CA 95814
Fax: (916) 323-0653
Email: Dhaddad@adp.state.ca.us